City of Milwaukee
CBP-157 R. 01/08/13

MEDICAL CERTIFICATION FORM

INSTRUCTIONS:
Attach this form as required to the application *for Absence Due to Personal Illness (CBP-156)* and forward to your Supervisor for review.

DATE:

I hereby certify that _____
(Name of Patient)

has been under my care for the period From: _____ To: _____

I certify that:
☐ the employee was unable to work, and
☐ the absence was medically necessary

The employee is released to return to work with the following restrictions:

These restrictions are in place for the following period:

Provider's Name:	
Provider's Title:	
Address:	
Telephone #:	
SIGNATURE:	